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Applicability: SCDDSN Autism Division, Regional Centers, DSN Boards and Contracted Service Providers

PURPOSE:

This directive establishes the agency's policy regarding the management of records relating to people receiving services through the Department of Disabilities and Special Needs and its network of service providers.

Records are maintained to provide complete and accurate information and for continuity of care, treatment, and training. The record will contain sufficient information to clearly identify the person, justify the diagnosis, reflect assessment of needs/goals, establish a plan for implementation of care, including training, treatment, and/or community services/supports, and accurately document results of implementation of the plan of care. In addition to complete and accurate documentation, the record will be readily accessible and systematically organized to facilitate retrieving and compiling information. It will be properly secured to ensure confidentiality for the person as well as their family.

For Agency Policy Regarding Confidentiality of Records, please reference 167-06 DD, Confidentiality of Personal Information.

TYPES OF RECORDS

1. Active records - records of people who are actively receiving services through the SCDDSN or a provider in the agency's network.
2. Inactive records - records of people who have been deemed to be ineligible for services, or were receiving services and have since been discharged out of SCDDSN or to another provider within SCDDSN's provider network, or are deceased.

TYPES OF DOCUMENTS

1. Vital documents - documents required by SCDDSN standards, other regulatory standards, or by law to be kept in the record until the end of the designated retention period or until any legal action/s are completed (whichever is longer). Vital documents among SCDDSN service delivery records most often fall into three categories.
 - a. Fiscal: These documents hold information that supports the expenditure of funds. These funds may be public funds or private funds, including those belonging to the individual.
 - b. Legal: These documents give evidence which addresses the legal rights of the person receiving services, obligations of SCDDSN to the person, or compliance with relevant laws and regulations.
 - c. Health: These documents record the current health status of the person, care and treatment currently received or needed, and significant health history.

Vital documents may include, but are not limited to, the Service Agreement, SCDDSN eligibility determination, contact/service/progress notes, service/treatment/program/support plans, and Medical Necessity statements, documentation of service delivery, service authorizations, signed consent forms, Level of Care determination forms and signed Freedom of Choice forms.

2. Non-vital documents - supporting information that should be destroyed when no longer needed for reference (Non-vital documents may include, but are not limited to, activity schedules, clothing inventories, STS or CDSS printouts, training programs, and copies of vital documents known as convenience copies made for short term use).

RECORDS CATEGORIES

ICF/MR

1. Intermediate Care Facility/Mental Retardation (ICF/MR) Residential [includes short term admissions]

NON-ICF/MR

1. Non-ICF/MR Residential [Residential examples are Community Training Homes (CTH), Supervised Living Programs (SLP), and Community Residential Care Facilities (CRCF).]
2. Day Programs [Day Program examples are Supported Employment, Child Development, Adult Activity Centers (including Rehabilitation Supports), and Sheltered Workshop.]
3. Family Support/Case Management [Family support/case management examples are Service Coordination, Respite, and Early Intervention.]

RECORDS MANAGEMENT AND ACCOUNTABILITY

Each service provider will assign the responsibility for management of and accountability for records to one person. This records manager will be held accountable for maintaining the records according to SCDDSN policy and according to the requirements of regulatory agencies, and must be given the authority to control their use.

Original records for anyone evaluated for services or for persons receiving services will be maintained by the service provider and **must be available during normal business hours** for review by all authorized persons. Copies of records - not original records or sole copy records - should be used when those records are required in places other than the service provider's location or service provider's authorized locations so as to reduce the possibility of loss.

Service Providers must have a policy to ensure that records are available as required and to ensure that adequate security safeguards are in place to prevent loss or unintended destruction of the contents of records. The policy must require a periodic accounting, no less than bi-annually, of active service recipient records (not each individual document); stipulate the manner and frequency with which this accounting will occur; require documentation of the results of the accounting; and indicate circumstances in which an unscheduled partial or total accounting of records will be conducted, such as upon termination of a caseworker.

Because records include confidential protected health information and/or confidential educational documents, any active or inactive record that cannot be made available in its entirety as stated above will be considered a lost record and therefore represents an unauthorized disclosure of information. Should this happen, the provider must:

- Report the loss of the record or document immediately to provider's HIPAA Privacy Officer. This person will then immediately telephone or email a brief report of the loss to SCDDSN's Privacy Officer. This brief report will then be followed by a detailed written report of the loss to the SCDDSN Privacy Officer. This written report should use the form identified as Attachment A, Record/Document Loss Report or the report should provide the same content. Together, these Privacy Officers are responsible for communication about and coordination of an appropriate response to the loss of the record. If the lost record is a Medicaid recipient's active record or inactive record for which the required record retention for Medicaid records has not been exceeded, SCDDSN will report the loss to SCDHHS.
- Notify the service recipient/legal guardian upon direction of SCDDSN. Documentation of this notification must be retained and be available in the service recipient's remaining or reconstructed case record.

Records should only be removed or destroyed in accordance with this policy. Failure to fully comply with this policy could result in disciplinary and/or legal action.

STORAGE, FILING AND RETRIEVAL

All records will be kept in a secure manner and stored so that information contained in the records is kept confidential and safe from damage or destruction. Active records should be kept at a location which allows ready access by agency staff, SCDDSN staff and other entities with a legal right to access. Inactive records should be stored in a central location by the service provider until the end of their retention period. Inactive records may be recorded using some suitable media to facilitate their security and/or to reduce required storage space.

ANNUAL REVIEW AND PURGING

Active records should be reviewed annually and all superseded documents and/or those no longer needed for reference should be moved from the working files to the holding files at the central storage site referenced above.

Inactive records will be reviewed annually and destroyed according to the current retention and disposition schedules. Any non-vital documents not previously destroyed should be destroyed as well.

RECORDS RETENTION AND DISPOSITION

The retention and disposition schedules of service delivery records are established with the SC Department of Archives and History through the Office of Information Technology at the Central Office of SCDDSN. As part of this process of establishing retention and disposition schedules, a records inventory determines which service delivery records are considered to be vital documents. Retention periods are based on SCDDSN standards as well as requirements of regulatory and relevant state and federal law. The goal of the retention and disposition schedules is to insure that records are retained long enough to meet all the requirements for audit and reference, yet be disposed of in a timely manner to reduce document handling and storage. Strict adherence to retention and disposition schedules is necessary for appropriate records management and will be monitored by SCDDSN's Internal Audit Department

Per SCDHEC regulations, Intermediate Care Facilities for the Mentally Retarded must retain all medical records for 10 years after the consumer's death or discharge; or the end of the provider's contract period with SCDDSN. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the ten (10) year period, the Provider will retain the records until the completion of the action and resolution of all issues which arise or until the end of the ten (10) year period (whichever is later).

Per SCDDSN standards and/or contracts and/or SCDHHS regulations and/or SCDHEC regulations, Community Residential Care Facilities, Community Training Homes, Supervised Living Programs; Adult and/or Child Day Programs; Early Intervention and Service Coordination providers must retain all vital documents for 6 years after the consumer's death or discharge; or the end of the provider's contract period. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the six (6) year period, the Provider will retain

the records until the completion of the action and resolution of all issues which arise from it, or until the end of the six (6) year period (whichever is later).

RECORDS MANAGEMENT AT TRANSFER AND DISCHARGE OF PERSONS

A. For the purposes of this document, "Transfer" involves the relocation of a person:

- from an ICF/MR residence to another ICF/MR residence within the same license and certified area; or
- from any program or service unit to any other program or service unit within the provider's territorial/program/contractual limits; and
- ICF/MR and Non ICF/MR transfers require all records to be relocated with the person being served to the receiving residence, program, or service.

B. For the purposes of this document, "Discharge" occurs when a person is relocated under any of the following situations:

- from one ICF/MR license to another ICF/MR outside of a licensed or certified area;
- from an ICF/MR to a non-ICF/MR program or service;
- from any program or service where the need for intervention with the person and or their family is no longer required because:
 - The person moves out of the provider's program;
 - The person no longer requires services;
 - The person dies.

ICF/MR and CRCF Records:

When a person moves from one licensed (by DHEC) facility within the SCDDSN/Provider network to another facility, the original record shall follow the person. In addition to a copy of the original record, the sending provider is required to maintain documentation of where the person was moved (and date of the move); last known home address, birth date, place of birth and social security number. If the receiving provider notes that documents are missing from the record, it will notify the sending provider in writing, request that the missing documents be forwarded and document this action in the person's record. If the sending provider has those documents, they will be forwarded immediately. If the sending provider is unable to locate those documents, they will be considered lost and actions required under **RECORDS MANAGEMENT AND ACCOUNTABILITY** will be initiated.

When the person leaves or relocates from a SCDDSN/Provider network facility to a location outside of the SCDDSN/Provider network, the last SCDDSN/Provider facility shall retain the person's original records and forward copies to the receiving facility.

All Other Records:

When a person moves within the SCDDSN/Provider network, the original record shall follow the person; in addition to a copy of the original record, the sending facility is required to maintain documentation of where the person was moved (and date); last known home address, birth date, place of birth and social security number. If the receiving provider notes that documents are

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missing from the record, it will notify the sending provider in writing, request that the missing documents be forwarded and document this action in the person's record. If the sending provider has those documents, they will be forwarded immediately. If the sending provider is unable to locate those documents, they will be considered lost and actions required under **RECORDS MANAGEMENT AND ACCOUNTABILITY** will be initiated.

When the consumer leaves or relocates outside of the SCDDSN/Provider network, the SCDDSN/Provider facility shall retain the person's original records and forward copies to the receiving facility.

The confidentiality of, access to, release of, and retention of education records (as defined by the most current regulations of the Individuals with Disabilities Act(IDEA)), including those created by SCDDSN or a qualified SCDDSN provider, are governed by the Family Education Rights and Privacy Act (FERPA), 34 CFR Part 99.

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Attachment A - [Record/Document Loss Report](#)